



BEACH EYE CARE

Neatrou Eye Institute

Office # 757-425-5550

Pt. Chart # _____

G. Peyton Neatrou, MD
Vivek Jain, MD
Teresa Shenouda, MD

Mark Lipton, OD
David Tang, OD
Jeffrey Dunn, OD
Cynthia Koza, OD

1201 First Colonial Rd.
Virginia Beach, VA. 23454

4388 Holland Road Unit 140
Virginia Beach, VA. 23452

2173 Upton Dr. Suite # 601
Virginia Beach, VA. 23454

Patient Information

PLEASE PRINT

Patient: _____
(Last) (First) (M.I.)

Name you prefer to be called _____

Address: _____

City State Zip

Sex: M F Age ____ DOB ____/____/____

Single Married Separated Divorced

Patient SS# _____
(For insurance purposes only)
**needed to file electronically for services

Occupation _____

Employer _____

Employer Address _____

Spouse's Name _____

How did you hear about Beach Eye Care?

(Select all that apply)

- From a Family Member
Name: _____
- From another BEC Patient
Name: _____
- From Another Doctor
Name: _____
- Insurance Carrier
- Internet
- Facebook
- Chamber of Commerce Member
- Radio
- Newspaper
- Yellow Pages
- ER/Urgent Care
- Beach Eye Care Employee
- Previous Beach Eye Care Patient
- Walk- In/Drive-By
- Hampton Roads Chamber of Commerce

PHONE NUMBERS

Home () _____ Work () _____

Cell () _____

Email _____

How would you like to receive appointment reminders?:(check all that apply)

Home Phone ____ Cell Phone via Text ____

Postcard ____ Email ____ All Listed (best) ____

Best time and place to reach you by phone?

IN CASE OF EMERGENCY, CONTACT

(Specify someone who does not live in your household.)

Name: _____

Relationship: _____

Home# _____ Work# _____

Primary Care Physician _____

Primary Care Physician #() _____

Pharmacy Name: _____

Pharmacy Number: _____

INSURANCE

Responsible Party:

Name: _____

Relationship: _____

Address: _____

Home () _____

Employer: _____

Work () _____

Responsible Party Signature:

EYE HEALTH HISTORY

Pt. Chart # _____

Eye Physician's Name _____ Date of last Visit _____

Place a mark on "YES" or "NO" to indicate if you have had any of the following:

- | | | | | | |
|---------------------------|--|--------------------|--|--------------------|--|
| Do you wear glasses | <input type="checkbox"/> Yes <input type="checkbox"/> No | Eye injury | <input type="checkbox"/> Yes <input type="checkbox"/> No | Loss of vision | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blurred vision – distance | <input type="checkbox"/> Yes <input type="checkbox"/> No | Keratoconus | <input type="checkbox"/> Yes <input type="checkbox"/> No | Lazy eye | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blurred vision – near | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glare difficulties | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpetic keratitis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Burning eyes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Floaters/spots | <input type="checkbox"/> Yes <input type="checkbox"/> No | Double vision | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cataracts | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Crossed eyes | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Color vision, poor | <input type="checkbox"/> Yes <input type="checkbox"/> No | Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No | Light sensitive | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Other Surgical History: _____

Is there any family history of?

- | | | | | | |
|-----------------|--|--------------------|-------------|--|---------------------|
| Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Relative(s): _____ | Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Relative(s): _____ |
| Retinal disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Relative(s): _____ | Cataracts | <input type="checkbox"/> Yes <input type="checkbox"/> No | Relative(s): _____ |
| Blindness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Relative(s): _____ | Keratoconus | <input type="checkbox"/> Yes <input type="checkbox"/> No | Relative (s): _____ |

OTHER: _____

Physician's Name _____ Date of last Visit _____

Have you ever had surgery for or suffered from any of the following medical conditions?

- | | | | | | |
|--------------|--|--|----------------------|--|--|
| | Allergy to Latex | <input type="checkbox"/> Yes <input type="checkbox"/> No | | Allergy to Iodine | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cold Sores | <input type="checkbox"/> Yes <input type="checkbox"/> No | Date _____ | Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Date _____ |
| Herpes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Date _____ | High blood pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Date _____ |
| HIV/AIDS | <input type="checkbox"/> Yes <input type="checkbox"/> No | Date _____ | Circulation problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Date _____ |
| Lung disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Date _____ | Heart condition | <input type="checkbox"/> Yes <input type="checkbox"/> No | Date _____ |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Date _____ | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No | Date _____ |
| Hepatitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | A B or C Circle which applies | | | |

Other: _____

REVIEW OF SYMPTOMS: Please mark ALL that apply

- | | | |
|---|---|---|
| <input type="checkbox"/> Weight loss | <input type="checkbox"/> Nasal congestion | <input type="checkbox"/> Abdominal pain |
| <input type="checkbox"/> Weight gain | <input type="checkbox"/> Nasal discharge | <input type="checkbox"/> Joint pain |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Nasal bleeding | <input type="checkbox"/> Muscle pain |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Neck pain | <input type="checkbox"/> Back pain |
| <input type="checkbox"/> Change in hair | <input type="checkbox"/> Neck swelling | <input type="checkbox"/> Slurred speech |
| <input type="checkbox"/> Change in nails | <input type="checkbox"/> Cough | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Rash | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Localized weakness |
| <input type="checkbox"/> Skin lesions | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Lymph node swelling |
| <input type="checkbox"/> Ear pain | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Ear discharge | <input type="checkbox"/> Nausea | <input type="checkbox"/> Substance abuse |
| <input type="checkbox"/> Difficulty hearing | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Cognitive function delay |

List Your Current Medications and Dosage:

List ALL Allergies (drug and non drug):

Patient Registration

Pt. Chart # _____

In an effort to contain our billing costs, we request that payment be made on the day services are rendered. For your convenience, we accept cash, check, VISA, Master Card and American Express. We also offer the availability of a financing program.

Patients covered by Medicare, Medicaid, Anthem, Champus (Tricare), or HMO's and PPO's of which we are participants, are required to pay their cost share or co-pay on the day of their visit. Patients who have not met their yearly deductible are expected to pay fully for services rendered. Our office must receive required referral forms before we are authorized by your insurance carrier to provide any services, as stated in your health insurance contract.

Blue Cross and Blue Shield claims filed for non-surgery charges become the patient's responsibility after 60 days of non-payment by your insurer. Surgical fees will be filed with both primary and secondary insurance carriers, with payments expected within 90 days from the date of service. Any balance after that time becomes the patient's responsibility.

- Please note that Medicare, Medicaid, and most insurance do not pay for refractions (\$42.00 fee)/or after-hours exams (an additional \$39.00 fee).
- It is an office policy to charge \$35.00 for the third "no show" or cancelled appointment with less than 24 hours notice, within a two-year period. A family appointment with three or more appointments in a given day that no show incurs a \$35.00 fee for each patient that day. Cancellations for Mondays must be received by 5:00 pm on Friday.

Insurance plans and vision care plans frequently do not cover certain testing that we find important in providing state-of-the-art eye care. These tests (and their fees) are described below so you are well informed as to their need. (If there is a medical diagnosis, thus covered by insurance, we will file to your insurance company.)

Please initial below by each test agreeing to pay the fee(s) indicated if NOT covered by your insurance.

(INITIAL) _____ **Refraction**-A refraction is when the technician or doctor places different lenses in front of your eyes to give the best vision for glasses and/or contact lenses. (fee is \$42.00 for a refraction.)

(INITIAL) _____ **Optomap Retinal Exam** -This advanced technology is highly recommended and used by the doctors to detect early signs of retinal disorders, including but not limited to: glaucoma, cancer, diabetic retinopathy, high blood pressure, macular degeneration, and retinal detachment. It is fast, painless, and comfortable. It is particularly helpful when you return for your annual exam as it provides a permanent record of your retinal condition, and each subsequent year the OPTOMAP images can be viewed side by side to discover subtle changes and monitor your continuing eye health. However, new technologies are often not covered by insurance plans. There is a **\$49 fee associated with the testing**. Insurance covers this with a medical diagnosis only. The digital images will be reviewed by the doctor in the exam room. This is an alternative to dilation. However, you may still be dilated.

The office staff will be happy to discuss fees with you and fully explain billing and reimbursement procedures. While we do everything possible to assist in obtaining insurance reimbursement, the final satisfaction of the fee for service remains the patient's responsibility.

Assignment and Release: I hereby authorize my insurance benefits to be paid directly to the physicians and authorize the release of any medical information necessary to process my claims. I also understand that I am financially responsible for all services rendered and any fees and /or interest imposed by outside agencies in effort to collect delinquent account balances.

Signature: _____ **Date** _____

Print Name: _____



Beach Eye Care

Consent for Release of Protected Health Information

I, _____, consent to the release of protected health information that is required to carry out treatment or payment of healthcare operations on my behalf.

I have read the Notice of Privacy Practices and am aware of the following:

- § I have the right to place restrictions on the way my protected health information is used or disclosed.
- § I understand that Beach Eye Care is not required to agree with my requested restrictions. I also understand that once Beach Eye Care agrees to my restrictions, it must comply with those restrictions.
- § I have a right to revoke my consent for the use and disclosure of my protected health information at any time. I understand that, if I choose to revoke my consent, I must submit a signed written statement.
- § I understand that Beach Eye Care must immediately comply with my request to revoke consent, except to the extent that it has already taken some action that was based on my original consent.
- § Beach Eye Care has reserved the right to change from time to time our privacy practices that are described in the Notice of Privacy Practices. Whenever we change our practices, we will modify the notice accordingly; and we will inform you *on your next visit*.

Individual:

Parent / legal guardian or Witness :

Printed Name

Printed Name

Signature

Signature

Date _____

Date _____

Pt. Chart # _____



Optical Information

How many pairs of glasses do you have? 1 2 3 4 more

If you wear glasses are they (circle)

For distance

For reading

For computers

Bifocals

Trifocals

Progressive (no line)

Do you wear prescription sunglasses? Yes No

Do you have difficulty driving at night due to glare? Yes No

How would you like to improve your current eyewear?

Weight

Thickness

Fit

Style

Shape

Durability

Size

Color

How do you use your eyes for daily or leisure activities: (Circle all that apply)

**Computer
Needlework
Hunting**

**Watching Television
Sports
Fishing**

**Driving
Golf
Piano**

**Reading
Swimming**

Other: _____

Contact Lens Information

How do you wear them?

Daily (take them out nightly)

**Continuously (sleep with them in)
If so, how many days: _____**

Please indicate your contact lens brand if known. _____

Monovision Multifocal

Are your contacts comfortable at the end of the day? YES NO

Are your contacts comfortable at the end of the wear cycle? (2weeks/1month) YES NO

How often do you dispose of your lenses? _____

What type of solution do you use? _____

Patient Copy

For Your Records

**Beach Eye Care
Notice of Privacy Practices**

THIS NOTICE DESCRIBES HOW PROTECTED MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

1. Beach Eye Care is permitted to make uses and disclosures of protected health information for treatment, payment and health care operations, as described in the following examples:
 - a. For treatment – Use in acquisition of referrals from PCP offices and referral to other specialists.
 - b. For payment – Use in collection of payments.
 - c. For health care operations – Use in keeping scheduling books.
2. Beach Eye Care is permitted or required, under specific circumstances, to use or disclose protected health information without the individual's written authorization.
3. Other uses and disclosures will be made only with the individual's written authorization, and the individual may revoke such authorization.
4. Beach Eye Care intends to engage in one or more of the following activities:
 - a. Beach Eye Care may contact the individual to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to the individual or patient.
 - b. Beach Eye Care may disclose protected health information to the sponsor of the plan, group health plan, health insurance issuer, or HMO with respect to a group health plan.
5. The Individual has the following rights regarding protected health information:
 - a. The right to request restrictions on certain uses and disclosures of protected health information. Beach Eye Care is not required to agree to a requested restriction.
 - b. The right to receive confidential communications of protected health information, as applicable.
 - c. The right to inspect and copy protected health information, as provided in the Privacy Regulation.
 - d. The right to amend protected health information, as provided in the Privacy Regulation.
 - e. The right to receive an accounting of disclosures of protected health information.
 - f. The right to obtain a paper copy of the notice from the covered entity upon request. This right extends to an individual who has agreed to receive the notice electronically.
6. Beach Eye Care is required by law to maintain the privacy of protected health information and to provide individuals with notice of its legal duties and privacy practices with respect to protected health information.
7. Beach Eye Care is required to abide by the terms of this notice currently in effect.
8. Beach Eye Care reserves the right to change the terms of this notice. The new notice provisions will be effective for all protected health information that it maintains.
9. Beach Eye Care will let our patients know of any changes done to the Notice of Privacy Practices at their next visit and the new notice will be posted in the reception area.
10. Individuals may complain to Beach Eye Care and to the Secretary of the Department of Health and Human Services, without fear of retaliation by the organization, if they believe their privacy rights have been violated. A brief description of how the individual may file a complaint follows:
Patient will fill out the patient complaint form provided to them and the form will then go to the Administrator.
11. Beach Eye Care's contact person for matters relating to complaints is:
 - a. April Gregory, HIPAA Officer
 - b. (757) 425-5550
 - c. 1201 First Colonial Road, Virginia Beach, VA 23454
12. This notice is first in effect on March 19th, 2003.
13. Beach Eye Care has elected to limit the uses or disclosures that it is permitted to make.

Revised 6/3/2010

14. Please be aware that parts of your examination maybe overheard by other patients. Let us know if this is a concern and accommodations will be made.